



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Memorial Compounding Pharmacy

Respondent Name

American Home Assurance Co

MFDR Tracking Number

M4-17-0658-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

November 07, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial Compounding Pharmacy has made numerous attempts to have the attached bills processed. Broadspire has yet to approve or deny our bills. Broadspire has not sent Memorial Compounding Pharmacy any type of correspondence, EOB, or payments on any of the attached bills. Proof of timely filing is attached along with all the attempts to have the bills processed. We are now requesting Medical Fee Dispute Resolution."

Amount in Dispute: \$2,285.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are in receipt of the above captioned medical fee dispute resolution. Payment has been disputed for date of service 4/20/16 as the medications were not preauthorized."

Response Submitted by: BROADSPIRE

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 28, 2016	Pharmacy services – Compound	\$2,285.25	\$2,285.25
May 27, 2016			
July 14, 2016			
August 15, 2016			

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240 sets out the procedure for medical bill processing by the workers' compensation insurance carrier.
3. 28 Texas Administrative Code §134.503 sets out the reimbursement for pharmacy services.
4. No explanation of benefits were found in the documentation.

Issues

1. Did American Home Assurance pay, reduce or deny the disputed services not later than the 45th day after receiving the medical bill?
2. Is the requestor entitled to additional reimbursement?

Findings

This medical fee dispute was filed by health care provider Memorial Compounding Pharmacy (Memorial) on November 07, 2016. Memorial on its table of disputed services asserts that it was not paid by American Home Assurance Co for the compound it dispensed to a covered injured employee on February 28, 2016; May 27, 2016; July 14, 2016 and August 15, 2016.

1. Memorial alleges that "Broadspire has not sent Memorial Compounding Pharmacy any type of correspondence, EOB, or payments on any of the attached bills."

According to Texas Labor Code Sec. 408.027 (b) American Home Assurance Co was required to pay, reduce or deny the disputed services not later than the 45th day after it received the medical bill from Memorial. Corresponding 28 Texas Administrative Code §133.240 also required American Home Assurance Co to take final action by issuing an explanation of benefits not later than the statutorily-required 45th day.

The following evidence supports that American Home Assurance Co initially received the medical bill for the services in dispute on August 2, 2016 and August 31, 2016.

- A copy of a certified mail receipt dated August 2, 2016, number 7014 2120 0004 2486 0583 addressed to Broadspire.
- A copy of a certified mail receipt dated August 31, 2016, number 7014 2120 0004 2485 2031 addressed to Broadspire.

Although there is evidence that American Home Assurance Co received a medical bill for the service in dispute on August 02, 2016 and August 31, 2016, American Home Assurance Co failed to timely take the following actions:

Rule §133.240 (a) An insurance carrier **shall take final action** [emphasis added] after conducting bill review on a complete medical bill...**not later than the 45th day** [emphasis added] after the insurance carrier received a complete medical bill."

Rule §133.240 (e) The insurance carrier **shall send the explanation of benefits** in accordance with the elements required by §133.500 and §133.501 of this title...The explanation of benefits shall be sent to:

- (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill...

Furthermore, American Home Assurance Co failure to timely issue an explanation of benefits to Memorial creates a waiver of defenses that American Home Assurance Co raised in its response to medical fee dispute resolution. According to Rule §133.307 (d)(2)(F):

28 Texas Administrative Code §133.307 (d)(2)(F) The [carrier's] response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

The Division concludes that American Home Assurance Co failure to timely issue an appropriate explanation of benefits creates a waiver of any new defenses presented in its response to medical fee dispute. Absent any evidence to the contrary, the Division finds that the services in dispute are eligible for payment.

2. Rule at 28 Texas Administrative Code §134.503 applies to the compound in dispute and states, in pertinent part:

(c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

- (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
 - (A) Generic drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;
 - (B) Brand name drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \4.00 dispensing fee per prescription = reimbursement amount;
 - (C) When compounding, a single compounding fee of \$15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or
- (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
 - (A) health care provider; or
 - (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately as required by 28 Texas Administrative Code §134.502 (d)(2).

Each ingredient is listed below with its corresponding reimbursement amount as applicable.

Date of Service February 28, 2016

Ingredient	NDC & Type	Price Gm	Total Gm	AWP Formula \$134.503(c)(1)	Billed Amount \$134.503(c)(2)	Lesser of (c)(1) and (c)(2)
Gabapentin	38779246109 Generic	\$59.85	3	\$195.71	\$156.75	\$156.75
Amitriptyline	38779018904 Generic	\$18.24	2.4	\$54.72	\$42.17	\$42.17
Amantadine HCL	38779041105 Generic	\$24.23	4.8	\$145.35	\$61.58	\$61.58
Flurbiprofen	38779036209 Generic	\$36.58	4.8	\$219.48	\$168.72	\$168.72
Bupivacaine	38779052405 Generic	\$45.60	1.2	\$68.40	\$48.02	\$48.02
Total			16.2	Total		\$477.24

Date of Service May 27, 2016

Ingredient	NDC & Type	Price Gm	Total Gm	AWP Formula \$134.503(c)(1)	Billed Amount \$134.503(c)(2)	Lesser of (c)(1) and (c)(2)
Versapro	38779252903 Generic	\$3.20	43.68	\$152.36	\$109.20	\$109.20
Ethoxy Diglycol	38779190301 Generic	\$0.34	3.6	\$1.54	\$1.23	\$1.23
Bupivacaine	38779052405 Generic	\$45.60	1.2	\$68.40	\$48.02	\$48.02
Flurbiprofen	38779036209 Generic	\$36.58	4.8	\$219.48	\$168.72	\$168.72
Amantadine HCL	38779041105 Generic	\$24.223	4.8	\$145.35	\$61.58	\$61.58
Amitriptyline	38779018904 Generic	\$18.24	2.4	\$54.72	\$42.17	\$42.17
Gabapentin	38779246109 Generic	\$59.85	3	\$224.44	\$156.75	\$156.75
Compounding Fee	NA	NA	NA	\$15.00 fee	\$15.00	\$15.00
			Total	63.48	Total	\$602.67

Date of Service July 14, 2016

Ingredient	NDC & Type	Price Gm	Total Gm	AWP Formula \$134.503(c)(1)	Billed Amount \$134.503(c)(2)	Lesser of (c)(1) and (c)(2)
Versapro	38779252903 Generic	\$3.20	43.68	\$152.36	\$109.20	\$109.20
Ethoxy Diglycol	38779190301 Generic	\$0.34	3.6	\$1.54	\$1.23	\$1.23
Bupivacaine	38779052405 Generic	\$45.60	1.2	\$68.40	\$48.02	\$48.02
Flurbiprofen	38779036209 Generic	\$36.58	4.8	\$219.48	\$168.72	\$168.72
Amantadine HCL	38779041105 Generic	\$24.23	4.8	\$145.35	\$61.58	\$61.58
Amitriptyline	38779018904 Generic	\$18.24	2.4	\$54.72	\$42.17	\$42.17
Gabapentin	38779246109 Generic	\$59.85	3	\$224.44	\$156.75	\$156.75
Compounding Fee	Na	Na	Na	\$15.00 fee	\$15.00	\$15.00
			Total	63.48	Total	\$602.67

August 15, 2016

Ingredient	NDC & Type	Price Gm	Total Gm	AWP Formula \$134.503(c)(1)	Billed Amount \$134.503(c)(2)	Lesser of (c)(1) and (c)(2)
Versapro	38779252903 Generic	\$3.20	43.68	\$152.36	\$109.20	\$109.20

Ethoxy Digycol	38779190301 Generic	\$0.34	3.6	\$1.54	\$1.23	\$1.23
Bupivacaine	38779052405 Generic	\$45.60	1.2	\$68.40	\$48.02	\$48.02
Flurbiprofen	38779036209 Generic	\$36.58	4.8	\$219.48	\$168.72	\$168.72
Amantadine HCL	38779041105 Generic	\$24.23	4.8	\$145.35	\$61.58	\$61.58
Amitriptyline	38779018904 Generic	\$18.24	2.4	\$54.72	\$42.17	\$42.17
Gabapentin	38779246109 Generic	\$59.85	3	\$224.44	\$156.75	\$156.75
Compounding Fee	Na	Na	Na	\$15.00 fee	\$15.00	\$15.00
Total			63.48	Total		\$602.67

The total reimbursement is therefore \$2,285.25. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$2,285.25.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$2,285.25, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Director for Medical Fee Dispute Resolution	8/17/2017 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.